DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 99-007A

2. STATE: MAINE

3 PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE(S)
8/1/99 FOR DENTAL SERVICES & 7/1/99 FOR ALL OTHER

5. TYPE OF PLAN MATERIAL *(CHECK ONE)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT:
a. FFY _____ $ _____
b. FFY _____ $ _____

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
~~PGS 36, 41, 77; ATT. 3.1-A, PGS 4A, 5, ATT TO 3.1-A, PG 5; SUPP. 1 TO ATT. 3.1-A PGS. 1-1(J); AND COMPLETE REPLACEMENT OF~~ ATTACHMENT 4.19-A

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: ~~PGS 36, 36A, 41 77; ATT. 3.1-A, PGS 4A, 5, ATT TO 3.1-A, PG 5; ATT. 3.1-A, PGS. SUPP. 1 TO ATT. 3.1-A PGS. 1-1(J); AND COMPLETE REPLACEMENT OF~~ ATTACHMENT 4.19-A

10. SUBJECT OF AMENDMENT: REQUIRED FRAUD AND ABUSE LANGUAGE
CHANGES TO TARGETED CASE MANAGEMENT SERVICES, DENTAL SERVICES AND HOSPITAL INPATIENT SERVICES.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED
COMMISSIONER, DEPT. OF HUMAN SERVICES

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Kevin W Concannon

13. TYPED NAME:
Kevin W. Concannon

14. TITLE:
Commissioner, Maine Department of Human Services

15. DATE SUBMITTED:
September 30, 1999

16. RETURN TO:
Francis T. Finnegan, Jr.
Director, Bureau of Medical Services
#11 State House Station
249 Western Ave.
Augusta, ME 04333-0011

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 9/30/99

18. DATE APPROVED: March 29, 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1, 1999

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Ronald P. Preston

22. TITLE:
Associate Regional Administrator, DMSO/HC

23. REMARKS:

FORM HCFA-179 (07-92)

Instructions on Back

OFFICIAL

45.09 COPAYMENT FOR INPATIENT SERVICES

45.09-1 Copayment Amount

A. A copayment will be charged to each Medicaid recipient receiving inpatient hospital services. The amount of the copayment shall not exceed $3.00 per day for inpatient of hospital services provided, according to the following schedule:

Medicaid Payment for Service	Maximum Recipient Copayment Per Day
$10.00 or less	$ .50
$10.01 - 25.00	$1.00
$25.01 - 50.00	$2.00
$50.01 or more	$3.00

B. The recipient shall be liable for copayments up to a maximum of $30.00 per calendar month for inpatient services, regardless of whether there are multiple hospital service providers within the same month. After the maximum $30.00 monthly cap(s) has been charged to the recipient, the recipient shall not be liable for additional copayments and the provider(s) shall receive full Medicaid reimbursement.

C. No provider may deny services to a recipient for failure to pay a copayment. Providers must rely upon the recipient's representation that he or she does not have the cash available to pay the copayment. A recipient's inability to pay a copayment does not, however, relieve him/her of liability for a copayment.

D. Providers are responsible for documenting the amount of copayments charged to each recipient (regardless of whether the recipient has made payment) and shall disclose that amount to other providers, as necessary, to confirm previous copayments.

45.09-2 Copayment Exemptions: No copayment may be imposed with respect to the following services:

A. Family planning services and supplies;

B. Services furnished to individuals under twenty-one (21) years of age;

C. Services furnished to any individual who is an inpatient in a hospital, skilled nursing facility, nursing facility, ICF-MR, or other medical institution, if that individual is required, as a condition of receiving services in that institution, to spend for costs of medical care all but a minimal amount of his or her income required for personal needs;

D. Services furnished to any recipient in a boarding home or foster home;

E. Services furnished to pregnant women, including services provided during the three months following the end of a pregnancy;

F. Services furnished to individuals receiving chemotherapy services;

G. All laboratory, radiology and pharmacy services;

H. Emergency services, i.e., when failure to provide the service could reasonably by expected to:

1. place the recipient's health in serious jeopardy,

2. cause serious impairment to bodily functions, or

3. cause serious dysfunction of any bodily organ or part.

I. Services furnished to an individual of a Health Maintenance Organization in which he or she is enrolled;

J. Recipients in State custody;

K. Recipients of Child Welfare Services.

Medicaid recipients exempt from copayment requirements are identified by a "NO" in the copay column on the recipient's Medical Eligibility Card.

A. **SWING-BED FOR NURSING FACILITY (NF)**

1. Reimbursement to Hospitals.

Reimbursement to hospitals for the provision of NF services to a patient in a swing-bed shall be made at the estimated statewide average rate per patient day for NF services.

2. Establishment of the Estimated Statewide Average Rate per Patient Day.

See attachment 4.19-D.

3. Ancillary Services.

Reimbursement to hospitals for ancillary services provided to Medicaid-eligible recipients staying in swing-beds will be in accordance with these Principles of Reimbursement.

B. HOSPITAL INPATIENT SERVICES

Reimbursement levels established for Medicaid covered services cannot exceed those established for similar Medicare covered services.

1. HOSPITAL INPATIENT SERVICES

Prospective reimbursement for non-critical access hospital inpatient services is made at the lower of the Target Amount Computation (TAC), or cost, or charges, as computed in accordance with the Tax Equity And Fiscal Responsibility Act (TEFRA), except as stated below plus a DSH adjustment payment for eligible hospitals.

Prospective reimbursement for licensed critical access hospital inpatient services shall equal the sum of the following components:

Total Inpatient Operating Costs + Inpatient Costs for the Professional Component for Hospital Based Physician Services + Inpatient Costs for Durable Medical Equipment and Supplies - Inpatient Third Party Liability Payments.

All calculations must be made in accordance with TEFRA, except as stated below, plus a DSH adjustment payment for eligible hospitals.

a. Medicaid Recipients Awaiting Placement at a NF

i. Reimbursement for Patients Awaiting Placement at a NF

Reimbursement to hospitals for services provided to Medicaid recipients awaiting placement at Nursing Facilities (NF's) shall be made prospectively at the estimated statewide average rate per patient day for NF services. At the time of audit by the Department of Human Services, the Department's final settlement will be based on the actual statewide average rate for NF services (whichever is applicable) for the period of time when services were rendered.

ii. Establishment of Prospective Estimated Statewide Average Rate Per Patient Day.

See Attachment 4.19-D.

iii. Determination of The Actual Average Statewide Rate Per Patient Day.

The actual average statewide rate per patient day shall be computed at the time of audit, based on the simple average of the NF rate (whichever is applicable) per patient day for the applicable State fiscal year(years) and prorated for a hospital's fiscal year.

4. MEDICAID PROSPECTIVE INTERIM PAYMENTS (PIP)

PIP = TEFRA Amount + DSH Adjustment

ACUTE CARE HOSPITAL AND PSYCHIATRIC CARE HOSPITAL (including state operated hospitals)

Hospitals shall be paid on a prospective payment basis in accordance with the Medicare Principles of Reimbursement.

The Department of Human Services' total annual prospective obligation to the hospitals shall be the **TEFRA,** Inpatient computed amount as described below. In addition, a disproportionate share hospital (DSH) adjustment shall be applied to the PIP if the hospital is a DSH eligible hospital. The Department of Human Services will pay each participating Medicaid hospital provider an annual total, as described here, for services provided to persons covered by the Medicaid program and certain maternal and child health programs of the Department. The Department will make equal weekly payments during the course of the payment year consistent with the total annual obligation.

CALCULATION OF PIP: the following components are summed for the non-DSH (*TEFRA*) portion of PIP (*Inpatient + NF days awaiting placement = TOTAL TEFRA (non-DSH)*). All data for these calculations are from the most recent hospital fiscal year end Medicaid cost report as filed with DHS Division of Audit.

INPATIENT COMPONENT: The lowest of:

1. The number of Medicaid discharges from the most recently completed year multiplied times the prospective TEFRA target amount per discharge for the year in which the PIP is effective. To this product is added, (1) Medicaid's share of program excludables, (2) Medicaid's share of Hospital Based Physicians and Graduate Medical Education costs, and (3) Inpatient third party liability payments are subtracted.

2. The Total Inpatient Operating costs net of Excludables from the most recently completed year inflated forward two years to current year utilizing the economic trend factor from the most recent edition of the "Health Care Cost Review: from DRI/McGraw-Hill. To this product is added, (1) Medicaid's share of Hospital Based Physicians and Graduate Medical Education costs, (2) Inpatient third party liability payments are subtracted.

3. The Total Inpatient Charges net of third party liability payments.

LICENSED CRITICAL ACCESS HOSPITAL INPATIENT COMPONENT: The Total Inpatient Operating costs from the most recently completed year inflated forward two years to current year utilizing the economic trend factor from the most recent edition of the "Health Care Cost Review: from DRI/McGraw-Hill." To this product is added,

(1) Medicaid's share of Inpatient Hospital Based Physicians and Graduate Medical Education costs, (2) Inpatient durable medical equipment and supplies costs. Inpatient third party liability payments are subtracted.

For purposes of this subsection, a Medicaid discharge for the most recently completed year is one with a discharge date occurring within the fiscal year and submitted prior to the end of the fifth month succeeding the FYE date. Total inpatient operating costs and charges are those associated with these discharges.

NF DAYS AWAITING PLACEMENT COMPONENT: The number of nursing facility census days at the hospital multiplied times the statewide average NF rate per day.

5. MEDICAID INTERIM VOLUME ADJUSTMENT

ACUTE CARE HOSPITAL AND PSYCHIATRIC CARE HOSPITAL

Medicaid claims data submitted in the first 150 days of the hospital's payment year, shall be analyzed to determine the accuracy of the prospective volume data utilized in the PIP calculation. If there is a deviation of at least five (5) per cent between the actual Medicaid inpatient volume and prospective Medicaid inpatient volume, an adjustment may be made to the PIP utilizing the actual volume data.

6. MEDICAID YEAR END RECONCILIATION

ACUTE CARE HOSPITAL AND PSYCHIATRIC CARE HOSPITAL

Fiscal year end reconciliation shall be accomplished for all hospitals in accordance with the **MEDICARE** Principles of Reimbursement.

The Department of Human Services' total annual obligation to the hospitals shall be the **TEFRA** Inpatient computed amount as described below. In addition, a disproportionate share hospital (DSH) adjustment shall be applied, if the hospital is a DSH eligible hospital. The Department of Human Services will pay each participating Medicaid hospital provider an annual total which when reconciled to the annual PIP shall show an **overpayment** by the Medicaid Program to the hospital provider or an **underpayment** by the Medicaid Program to the hospital provider.

For an **overpayment**, the hospital shall reimburse the Department for the excess payments; and, for an **underpayment**, the Department shall remit the amount of the underpayment to the hospital in a lump sum payment. In either case, the payment shall be made within 30 days of the letter notifying the provider of the results of the year end reconciliation. If more than one year is completed in the same proceeding the amounts may be summed or netted together as applicable.

CALCULATION OF MEDICAID OBLIGATION: the following components are summed for the non-DSH (*TEFRA*) portion of the total inpatient obligation (*Inpatient + NF days awaiting placement = TOTAL TEFRA (non-DSH)*). All data for these

calculations are from the hospital Medicaid cost report as filed with DHS division of audit five (5) months after the fiscal year end.

NON-CRITICAL ACCESS HOSPITAL INPATIENT COMPONENT: The lowest of:

1. The number of Medicaid discharges from the completed year (FYE plus 5 months) multiplied times the TEFRA target amount per discharge. To this product is added, (1) Medicaid's share of program excludables, and (2) Medicaid's share of Hospital Based Physicians and Graduate Medical Education costs. Inpatient third party liability payments are subtracted.
2. The Total Inpatient Operating costs net of Excludables from the completed year plus Medicaid's share of Hospital Based Physicians and Graduate Medical Education costs, less Inpatient third party liability payments.
3. The Total Inpatient Charges net of third party payments.

LICENSED CRITICAL ACCESS HOSPITAL INPATIENT COMPONENT: The Total Inpatient Operating costs from the completed year plus Medicaid's share of Inpatient Hospital Based Physicians and Graduate Medical Education costs, plus Medicaid's share of Inpatient durable medical equipment and supplies costs, less Inpatient third party liability payments.

NF DAYS AWAITING PLACEMENT COMPONENT: The number of nursing facility census days at the hospital multiplied times the statewide average NF rate per day.

7 MEDICAID FINAL AUDIT SETTLEMENT

The final audit settlement shall be in accordance with the Medicare Principles of Reimbursement, and cost settled with the hospitals upon receipt of the audit from the Medicare fiscal intermediary.

C DISPROPORTIONATE SHARE HOSPITALS (DSH)

A psychiatric care hospital having a Medicaid inpatient utilization rate (based on charges) which equals 1% or greater will be defined as a disproportionate share hospital.

Any hospital meeting the minimum criteria below will be defined as a disproportionate share hospital:

1. The hospital must (a) have a Medicaid inpatient utilization rate at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the state (as defined in Section 1923 (b)(1)(A) of the Social Security Act), or (b) have a low-income inpatient utilization rate (as defined in Section 1923 (b)(1)(B) of the Social Security Act) exceeding 25%; and

2. The hospital must have at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under a State Medicaid plan. In the case of a hospital located in a rural area (that is, an area outside of a Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures.

3. The obstetric related criteria in subsection 2 above, do not apply to hospitals in which the inpatients are predominately individuals under 18 years of age, or to hospitals which did not offer non-emergency obstetric services as of December 21, 1987.

4. For purposes of determining whether a hospital is a disproportionate share hospital in a payment year, the Department will use data from the hospital's Medicare as-filed cost report for the same period to apply the "standard deviation" test of subsection 1(a) above and draw charge data from that period to apply the "25%" tests and "1%" tests within this section. If at the time of final audit the as-filed cost reports prove to be inaccurate to the degree that a hospital's disproportionate share status changes, adjustments will be made at that time.

1. PROSPECTIVE DSH ADJUSTMENT PAYMENTS

In establishing prospective adjustment payments to a psychiatric care hospital (excluding State run facilities), the Department will rely upon data from the payment year two years prior to the current payment year to determine the prospective adjustment payments to the hospital.

If the data shows that a psychiatric care hospital has met the criteria which describes a disproportionate share hospital and that the hospital has a Medicaid utilization rate, based on inpatient days of one percent as defined in Chapter II Section 45.01-9(1)(c), it shall be reimbursed prospectively at a rate equal to that set forth in C(1)(a) or (b) of this section, plus an additional payment for services provided to patients eligible for medical assistance under the approved Title XIX and Title XXI State plan and services provided to low-income patients. Effective for dates of services on or after July 1, 1998, the prospective DSH payment will be adjusted to the State fiscal year budgeted amount.

The Medicaid utilization rate (**MUR**) formula, based on patient days, shall be computed as:

MUR % = 100 X **M/T**

M = Hospital's number of inpatient days attributable to patients who for these days were eligible for Medical Assistance under the State Plan.

T = Hospital's total inpatient days

In calculating the Medicaid inpatient utilization rate (**MUR**), the State shall include

newborn days, days in specialized wards, administratively necessary days, and days attributable to individuals eligible for Medicaid in another State. The State shall not include, however, days attributable to Medicaid patients between 21 and 65 years of age in Institutions for Mental Disease(IMDs).

Hospitals which qualify as a disproportionate share acute care hospital will receive the estimated disproportionate share adjustment, which shall be limited to the lesser of:

a. The disproportionate hospital adjustment payment which shall be composed of the actual cost of services, furnished to Medicaid patients, plus the cost of services, provided to uninsured patients (those who have no health insurance or other third party resources which apply to the service for which treatment is sought), less the amount of payments made by those patients, or

b. the disproportionate hospital adjustment payment due the hospital, as prescribed under the statewide aggregate disproportionate share hospital payment cap established by the Health Care Financing Administration. The aggregate cap includes DSH payments made to all acute care facilities and all institutes for mental diseases. Total DSH payments cannot exceed the aggregate cap established by the Health Care Financing Administration (HCFA). If the Department, determines that aggregate payments, as calculated under (a), would exceed the cap established by HCFA, payments will be determined as follows:

   i. For hospitals designated as Institutions for Mental Disease, the cost of services provided to Medicaid patients, less non DSH payments made by the State, plus the cost of services provided to uninsured patients less any cash payments made by them, or

   ii. For all other disproportionate share acute care services provided, all DSH payments will be proportionately reduced, according to the aggregate amount established by HCFA and determined to be available by the State. The original DSH payment percentage determined for each hospital would be applied to the total aggregate DSH payment amount (cap) available.

2. FINAL RECONCILIATION DSH ADJUSTMENT

At the time of final reconciliation any hospital that is determined to be a disproportionate share hospital shall be reimbursed at the amount described in (B)(1) of these allowances plus an additional DSH payment that shall be limited to the